TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Physicians Surgical Hospitals

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-17-3402-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was placed with EnableComp by the client, Ardent Health Services, on 11/22/16. It was worked by the Revenue Specialist on 12/02/16."

Amount in Dispute: $12,051.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's bill is untimely. Texas Mutual received the bill 3/6/17. The creation date of the bill is 3/6/17, a date that exceeds 95 days from 11/1/16, the date of service. Further, the only explanation provided by the requestor is "…we did work this account within timely filing limits…" but failed to submit the bill timely."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 1, 2016	27759 -LT	$12,051.30	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements of submission of medical bills by health care providers.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired

- W3 – In accordance with TDI-DWC Rule 134.804 this bill has been identified as a request for reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Did the requestor waive their right to Medical Fee Dispute?

Findings

1. The requestor is seeking $12,051.30 for outpatient hospital services rendered on November 1, 2016.

   The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired." Review of the submitted documentation found a request for payment to the injured workers employer (Quality Beef Producers) for the services in dispute on December 2, 2016.

   28 Texas Administrative Code §133.20 (j) states,

   The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill(s). Such billing is subject to the following:

   (1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to:

   (A) prompt payment, as provided by Labor Code §408.027;

   (B) interest for delayed payment as provided by Labor Code §413.019; and

   (C) medical dispute resolution as provided by Labor Code §413.031.

   Based on the above, the Division finds the requestor has waived their right to medical fee dispute as they did elect to submit a payment request to the injured workers employer.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 11, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.